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WORLD MEDICAL ASSOCIATION
GENERAL ASSEMBLY IN LONDON

International Standards of Medical Practice

The national medical associations of 28 countries were represented by twice that number of delegates at the third annual assembly of the World Medical Association, which was held at B.M.A. House, London, from October 11 to 15. In addition to the delegates the meeting was attended by observers from WHO, Unesco, ILO, the World Federation for Mental Health, and various international medical organizations. Observers were also attached to several of the delegations, and 30 members of the United States Committee—the supporting organization of the WMA in America—were present in the same capacity.

The following are the countries from which the delegates came: Australia, Austria, Belgium, Canada, Colombia, Cuba, Denmark, Eire, Finland, France, Great Britain, Greece, Iceland, India, Italy, Luxembourg, Netherlands, Norway, Pakistan, Peru, Philippines, Portugal, South Africa, Spain, Sweden, Switzerland, Turkey, United States of America.

The delegates from the British Medical Association were Dr. H. Guy Dain and Dr. J. A. Pridham, with Dr. E. A. Gregg and Dr. S. Wand as alternates. Dr. John Yui, of the Chinese Medical Association, was not able to attend, but he sent a cablegram of greeting, and the assembly was continually reminded of its Far Eastern affiliation by the Chinese temple gong—a gift by Dr. Yui at a previous meeting—with which the president kept the delegates in order. The languages spoken were English and French, with occasional Spanish. Dr. Gérin-Lajoie, of Canada, rendered excellent service as an interpreter.

Election of Dr. Charles Hill as President

The assembly opened on the morning of October 11 with a welcome to the delegates by the outgoing President, Professor Eugène Marquis (France), who referred to two large pieces of work which the Association had already accomplished—its declaration on the punishment of war crimes by medical men, and the Declaration of Geneva, a modern version of the Hippocratic Oath. He then moved confirmation of the election of Dr. Charles Hill as President, saying that in all countries they knew enough of Dr. Hill's quality to be sure that under his guidance the Association would make great progress.

The election having been unanimously confirmed, Dr. Hill took the chair, and, after expressing his sense of the honour done to him, proceeded to thank Professor Marquis in the name of the assembly for his outstanding services as first President of the Association. The Chairman of Council (Dr. T. C. Routley) and Dr. Dag Knutson (Sweden) spoke in similar terms, and the former asked the President to present to Professor Marquis in token of his term as President a suitably inscribed gavel; and this was done, the delegates standing and applauding.

Certain formal business was then taken, including the admission to membership of two national medical associations which had qualified under the articles—namely, the Asociacion Medica Nacional of Panama and the Colegio Medico of Salvador.

The Finance of the Association

Dr. O. Leuch, the Treasurer, presented the accounts for the past year and the budget for 1949–50. He said that the Council had decided that for the coming year the annual subscription for countries in the sterling area should remain at the same amount as for 1948–9. National associations in the sterling area, if their membership had not increased, would pay no more than before, notwithstanding the devaluation of their currencies. The whole matter would be reconsidered next year. Dr. L. L. Davey (Australia) expressed appreciation of this decision.

Dr. L. H. Bauer (Secretary-General) brought forward the annual budget of the United States Committee. He recalled that at the meeting in Paris in 1947 the U.S. delegation had offered to subscribe 50,000 dollars a year for five years to get the Association on its feet financially. That was accepted, and in 1948, although the committee was operating only for nine months of that year, the amount actually expended was 59,481 dollars, and for the first half of 1949 29,484 dollars. For 1950 the tentative budget was 75,700 dollars.

The committee had been established as a non-profit organization. The American Medical Association, in addition to its annual subscription to the WMA, was a contributing member of the U.S. Committee, as were other medical organizations in the States, as well as certain well-recognized pharmaceutical houses. An effort had been made to interest individual doctors in the matter by proposing a subscription of 10 dollars a year, and this year 12,000 dollars had been subscribed by individual doctors.

Dr. Leuch moved a vote of thanks to the U.S. Committee, and especially to the leaders of the American Medical Association who had created it. The motion was supported by Dr. Knutson, who said that most doctors did not know what was going on outside their own association, and the American example should be copied in every country.

Report of the Council

Dr. Routley, in presenting the report of the Council, said that three meetings had been held—in Geneva, in Madrid, and in London. The report dealt with a number of matters, but he wished to make it clear that it was the view of the Council that the Association should not attempt to propose to any member-country how it should conduct its affairs; its function was to make known to all countries the information which reached it and to endeavour so far as possible to maintain international standards of medical practice.

Dr. Routley went on to indicate certain proposals, all of which were adopted, for the future programme of the Association. The first was a proposed conference for the co-ordination of scientific medical organizations. He said that the Council was not unmindful of the activites of Unesco in this field, and had no desire to overlap, but what they had in mind was something beyond the scope of Unesco activities. The Council also proposed to make a study of pharmaceutical practices, including the newer therapeutic agents (the sulphonamides, penicillin, streptomycin, etc.), the extent to which these agents were available in different countries, any government subsidies affecting their distribution, and any restrictions on prescribing these agents, either in private practice or in social security schemes.

A further study proposed concerned hospitals, their types (government, private teaching, etc.) in each country, the number of hospital beds in relation to the population, the availability of hospital facilities, and the control and financial support of hospitals.

Further, a study of the status of the medical profession, especially in relation to medical man-power and membership of the national associations in the different countries, was proposed. This would be supplementary to a study which the Association had already published, concerning 23 countries, dealing with medical man-power and other subjects.

Dr. O. Rasmussen (Denmark) asked whether it would not be wise to include in this last study an examination of the economic position of doctors in different countries in relation to that of other professions. Dr. Routley said that this suggestion had much merit, and unless there were objections which did not occur to him at the moment he would agree on behalf of the Council that this study should include the wider field of economic relationships.

The reports and proposals of the Council were all accepted by the assembly, and Dr. Routley concluded by expressing appreciation of the help afforded by the Assistant Secretaries for Asia, Australasia, Europe, and Latin America respectively; by the editor of the *Bulletin*, Dr. Morris Fishbein, and his collaborating editors, and by the observers on intergovernmental organizations, such as the WHO. The WMA must be to WHO, he said, what electric power was to the transmission line.

The assembly adopted an emblem—a globe, with the rod of Aesculapius placed diagonally across it, and around the border the words "Societas Medicorum Mundi. MCMXLVII A.D."

Reports from the Continents

Three of the Assistant Secretaries—the fourth, Dr. J. G. Hunter for Australasia, has only recently been appointed and was not present—gave brief reports. Dr. S. C. Sen, for Asia, said that of 16 countries in his region four were represented in the WMA. In India at the present moment the problems engaging the attention of the Government and the medical profession concerned the recognition, status, and educational standard of the indigenous systems of medicine, known as Ayurveda, Unani, etc., a scheme in connexion with the Employees Insurance Act, and the establishment of new medical colleges and upgrading of departments in colleges with a view to providing facilities for research and post-graduate education.

Dr. Paul Cibrie, Assistant Secretary for Europe, reported that it had been impossible to correspond with three countries which originally adhered to the Association—Poland, Czechoslovakia, and Rumania. An inquiry was being made into the activities of the Red Cross in time of peace; it appeared that in some European countries certain activities of the Red Cross invaded the sphere of general medical practice. The outstanding event of the year in Europe was the inauguration of the National Health Service in Great Britain, but that, if it came before the WMA at all, would properly be introduced by the British delegates.

Dr. J. A. Bustamante, for Latin America, described the activities of the Pan-American Medical Confederation, which ran parallel in Latin America with those of the WMA. Dr. Bustamante himself was secretary-general of the Confederation, so that the liaison could not be closer. Chile, Colombia, Cuba, Peru, Guatemala, Venezuela, and Ecuador had entered the WMA.

International Code of Medical Ethics

Up to this point the proceedings of the assembly had presented no points of controversy, but the President said that now they came to a series of important reports which invited a lively exchange of views. The first of these was a proposed International Code of Medical Ethics, which incorporated the Declaration of Geneva, adopted by the general assembly in September, 1948, and a code setting out the duties of doctors in general and to the sick. Dr. Paul Cibrie, chairman of the committee which had elaborated the code, said that this was discussed a year ago. The code contained no more than general rules for the good practice of medicine. It was for each country to modify the wording for use within its borders, provided the principles of the code were respected. He moved that the code be approved.

Dr. P. Moran (Eire) took exception to a reference in the code to therapeutic abortion. The paragraph read:

"A doctor must always bear in mind the importance of preserving human life from the time of conception. Therapeutic abortion may only be performed if the conscience of the doctor and the national laws permit."

No one should have any right, except by judicial process, to pronounce sentence of death. The Association should not do anything which would make easier the path of the abortionist. Otherwise, where were they going as a profession? He moved that the reference to therapeutic abortion be omitted.

Dr. Paul Cibrie (France) reminded the last speaker that only a very severe condition would permit in certain countries the operation of therapeutic abortion. The abortionists were condemned implicitly in the declaration of Geneva.

Dr. W. Magner (Canada) supported Eire, although, he said, the question of therapeutic abortion had never been discussed by the Canadian Medical Association; and the Irish point of view was also supported by Dr. F. Sondervorst (Belgium), Dr. L. G. Tornel (Spain), and the Austrian and Portuguese delegates. Dr. J. A. Pridham said that Dr. Moran had stated that in no circumstances must a doctor commit murder. But murder could be committed either by deed or refraining from deed. If a doctor, after consultation with his colleagues, was certain that a woman would die unless therapeutic abortion was performed, and yet allowed the pregnancy to continue, might he not morally be guilty of murder? Dr. S. C. Sen (India) said that the question might arise whether to preserve the mother's life or the life of the foetus, and therefore it might be wiser to delete this sentence and leave it to the conscience of the professional man and the laws of his country. Dr. L. L. Davey (Australia) suggested that the governing consideration should be the welfare of the mother.

On a division the amendment to delete the sentence was lost by 19 to 22. Later, however, in view of this narrow vote, it was agreed to appoint a small committee to consider this whole paragraph, and on the following day the committee reported its view that the paragraph should simply read:

"A doctor must always bear in mind the importance of preserving human life from conception until death"—

leaving out any specific reference to therapeutic abortion, and in this form it was adopted by the assembly.

Duties of Doctors to the Sick

Dr. O. Rasmussen (Denmark) took up a statement in the report that it was unethical to participate in any plan of medical care "in which the doctor does not have complete professional independence." He objected to the word "complete," which in his view represented something unattainable. The assembly agreed to delete the word.

Dr. Sen found fault with the expression used in another paragraph, where it was stated that if a doctor found examination or treatment beyond his capacity he should "summon" another doctor. In his view the word "summon" had a legal connotation, but here the assembly adhered to the original text.

Various other emendations of the document were proposed, but the only one that found favour was a rewording of a paragraph as follows (on the proposition of the Luxembourg delegate):

"Under no circumstances is a doctor permitted to do anything that would weaken the physical or mental resistance of a human being, except for strictly therapeutic or prophylactic indications imposed in the interest of the patient."

The document was then approved, and it was agreed that it be left to national medical associations to modify the wording of the code, provided that any altered wording conformed to the principles which the code set out.

The WMA Bulletin

Before the assembly adjourned Dr. Morris Fishbein, editor of the WMA *Bulletin*, gave a brief report. Three numbers of the *Bulletin* had now been issued, and a proposal was being considered that six numbers be issued each year instead of four. He hoped that ultimately the *Bulletin* might prove to be the main financial support of the Association. It was the first medical publication to be published simultaneously in three languages. Incidentally, one of the editing difficulties was that the Spanish translations required 10% more words than the English or French. Dr. Fishbein gave some amusing instances of translators' difficulties. In another year

he thought the *Bulletin* would be on a firm foundation. Dr. Sondervorst (Belgium) said that in his own country they were very touchy about translations, which he hoped would continue to improve.

Postgraduate Education and Specialist Training

On the second day of its meeting the assembly, again under the presidency of Dr. Charles Hill, addressed itself to a report on postgraduate medical education and specialist training. The report—a long and exhaustively tabulated document—set out the results of a questionary to which the national medical associations in 32 countries had returned answers concerning the existence and establishment of standards for specialists, the period and type of training, details of examinations, certificates, schools, faculties, recognized specialties, and the opportunities for advanced education for doctors not interested in becoming specialists.

Dr. J. A. Pridham, in submitting this report, said that it embodied the results of work which only the WMA could have undertaken. The study had shown that the level of postgraduate education differed widely in different parts of the world, and so did the facilities for such education. He suggested to the assembly that here they had the possibility of doing something really valuable. It did not suffice for one country to go ahead in this field and leave other countries in a backward state. In view of the universal ethical standard which they had proclaimed, doctors in the more advanced countries should surely assist other countries to raise their own standards of education and practice. In that way they would be doing something to fulfil one of the main objects of the WMA—which was the maintenance of world peace.

He added that the report drew attention to the need for the continued education of the general practitioner, an important condition in any national scheme of medical care. It was obvious that there was a fear in many countries that the family doctor might be squeezed out, and that too large a proportion of men, on qualification, might seek to become specialists.

Dr. A. P. Cawadias (Greece) spoke on the education of the specialist. With the development of medical science the general consultant was disappearing. In future they would speak of specialists only. He emphasized the need for a generous pre-professional education. In the Greek universities there were severe examinations before professional education was embarked upon. He believed that this background of general culture was even more necessary for the specialist than for the general practitioner. Something should be done to ensure that examinations for specialists exacted a certain standard of general culture.

Dr. Paul Cibrie (France) declared himself not in entire agreement with this Athenian point of view. The general culture of the general practitioner should be on the same level as that of the specialist. He was not in favour of cultural hierarchies in the medical profession. General practitioners must not be regarded as at the bottom of the ladder and specialists as at the top.

Dr. F. Sondervorst (Belgium) objected to a proposal in the report that where a doctor's remuneration came mainly from a State social insurance scheme that scheme should finance his refresher course. In his view the course fees and expenses should be paid by the doctor himself or provided by scholarships or fellowships.

"Looking Down" on the General Practitioner

Dr. S. C. Sen (India) said that there seemed to be a tendency for specialists to regard themselves as belonging to the higher strata of the profession, and a tendency also to extend the period of specialist training. He believed that in Austria they insisted upon six years' additional education if a man was to become a specialist. Medical education was already sufficiently expensive and time-consuming. He thought they should emphasize the minimum standard and not expect to decide on the maximum. He deplored a tendency to "look down" on general practitioners. In the United States they were now setting up specialists in general practice, and an academy of general practice had been established, recognized by the American Medical Association, and requiring its members to undertake 150 hours' training every three years. The background of general culture had been mentioned, but culture should not be narrowly interpreted as a matter of leisure and books, but rather of tolerance and a wide outlook upon life. He suggested also that a knowledge of ancient Eastern philosophies should be regarded as a cultural equipment equal to Latin or Greek.

Dr. Morris Fishbein (United States) objected to a suggestion in the report that "wherever possible there should be general practitioner hospitals, or general practitioner beds in ordinary hospitals where he [the general practitioner] may attend his own cases and call in the help of his specialist colleagues." It was an error to propose hospitals for general practitioners as distinct from hospitals in which both general practitioners and specialists carried on their work. This proposal would promote disruption in the profession. The tendency in countries where there was a State medical service had been to make the general practitioner "second class." He was considered to be one who merely directed cases to a specialist. Yet if the progress of medicine were studied in recent years the tendency seemed to be to give the general practitioner increasingly the care of cases which formerly went to the specialist. This had come about because of the advent of antibiotics, also blood transfusion and the use of blood products, as well as other advances. In the field of otolaryngology, for instance, little remained for the specialist except such things as the fenestration operation, and in the field of dermatology the specialist was left with only a few conditions to which he could give a name but for which he had no treatment! There should be complete integration of the general practitioner in the hospital services, with adequate representation on the staff of the hospital and on the executive medical committee.

Dr. L. G. Tornel (Spain) also was of the opinion that the general practitioner should be ranked as highly as any specialist. Dr. K. E. U. Jäämeri (Finland) held the same view. In his country too much importance had been attached to the scientific status of those who held posts in institutions. Dr. Dag Knutson (Sweden) said that it was not so much that others looked down upon the general practitioner as that the general practitioner seemed inclined to look down upon himself by referring patients to specialists more and more quickly, as though afraid to handle them himself. The general practitioner was the backbone of medicine, but if he was content to accept an economically lower status than the specialist he would continue to be looked down upon.

Dr. W. Cline (United States) proposed the following words as an improved version of what was stated in the report:

"In addition hospitals should welcome visits from general practitioners. Posts should be made available to them. Such posts are of benefit both to the specialist and the general practitioner. There should be general practitioner beds in ordinary hospitals, and general practitioners should be integrated into the hospital service. In this manner a general practitioner will become a better doctor and have more interest in his work."

Asked what he meant by an "ordinary hospital," he said that he meant one from which cases requiring certain special care, such as cases of mental disease and perhaps tuberculosis, were excluded. Asked if he would include teaching hospitals, he said that this would depend upon local circumstances. Some hospitals found it advisable for the training of medical students to utilize the services of general practitioners, although the bulk of the teaching was done by specialists.

Professor K. Fellinger (Austria), Dr. O. Rasmussen (Denmark), and Dr. F. Wibaut (Netherlands) said that in their countries owing to the system of hospital administration it would be impossible to put this proposal into effect.

Dr. Routley (Chairman of Council) said that they were losing sight of the fundamental principles of the WMA. The Association did not dictate to any member-association. It was for each association to apply the spirit of the resolution in the way it found best.

The version suggested by Dr. Cline was adopted, with the deletion of the word "ordinary," and with the insertion of the words "where possible" before "posts should be made available to them."

Period of Practice under Supervision

Certain recommendations of the committee were adopted. The first was that every doctor, after obtaining his licence to practise, should spend a period during which he practised under supervision, usually in hospital, but possibly as assistant to a general practitioner. Dr. Harvey Pirie (South Africa) said that in his country the importance of this had recently been recognized, and it was now legally compulsory for medical graduates to do a year's internship or occupy some approved post before they could be admitted to the *Register* and take up independent practice.

It was also agreed that to become a specialist it was necessary to obtain an adequate postgraduate training, particularly in the field of the specialty. National medical associations were requested to endeavour to secure by mutual arrangements that opportunities for postgraduate studies and practical experience should be made available to members of the profession from other countries. It was realized that to accomplish this it might be necessary in the respective countries to overcome legal and other difficulties.

Dr. H. Guy Dain said that one of the provisions of the new Medical Act in Great Britain would be to provide that a graduate of another country coming here for further study might be placed on the British *Register* temporarily whilst he was engaged in his studies here in order to give him the opportunity for taking responsibility for cases without offending the principal Medical Act. He would be allowed to practise in this country for a limited period and be able to take charge of cases because he would be officially on the *Register*.

The final recommendation on this subject, which was agreed to, was that the national medical associations and the various international organizations should arrange an exchange of information regarding vacancies and opportunities for graduate and postgraduate study in foreign countries.

Progress reports were submitted by the Committee on Medical Care and Allied Subjects (dealing especially with efforts to improve the medical libraries of the world), and the Committee on Ways and Means of Securing Publicity. It was reported that a Committee on Standard Nomenclature had been appointed.

Reports of Observers on Intergovernmental Bodies

Dr. J. Maystre, the Association's observer on WHO, gave a brief account of the WHO assembly in Rome, and said that the relations between the two bodies were permanent and official. An inquiry of WHO on the use of habit-forming drugs had been entrusted to WMA.

Dr. M. H. Hafezi, of WHO, brought the best wishes of its Director-General, and spoke of collaboration in many subjects. The WMA was WHO's main link with the medical profession.

Dr. H. Guy Dain asked whether WHO was proposing to deal with questions of medical ethics in any sense through a committee. In Great Britain they would resent having any code of medical ethics imposed upon them by a partly lay body.

Dr. Maystre said that when this matter came before the Executive Council of WHO he drew attention to the work of WMA, and the Director-General was instructed to hold it in abeyance until WMA had taken some action. He was also asked about the action of WHO in respect of an international pharmacopoeia, and said that WHO was attempting only to formulate nomenclature that could apply to all countries, but the list of remedies was not limited.

Dr. Fishbein said that he was a member of the board of directors of the *U.S. Pharmacopoeia*. The Commission of WHO which was concerning itself with an international pharmacopoeia was composed of representatives in the field of pharmacy and pharmacology and had no representative of medicine. The proposal to have a selected list of remedies—a list of 141 drugs for which common names might be chosen throughout the world—had various implications. In some countries endeavours were being made to restrict the right of the physician to prescribe what he thought best for the patient. This must limit choice in prescribing and contribute to the lowering of the status of the general practitioner, and would tend also to inhibit progress in the field of research.

Dr. Hafezi mentioned the care with which experts were selected for the committees of WHO. With regard to drugs, it was not proposed in any sense to replace national pharmacopoeias, but only to endeavour to arrive at common standards.

The President said that they were grateful to Dr. Hafezi. He would understand that national medical associations by tradition were vigilant in observing what their respective governments did, and that assembly as representing the medical associations of the world would be equally vigilant in watching the work of WHO. But they looked forward to the closer collaboration which had been promised.

Dr. Maystre also gave a report as observer on ILO and its activities in social security. Dr. Manuel de Viado, who attended as an observer from ILO, also brought greetings from the Director-General, and said that ILO had fully documented information about the medical services of 62 countries. It was anxious to collaborate and exchange information.

Dr. Maystre gave one further report, as liaison officer at the recent Diplomatic Conference for the Establishment of International Conventions for the Protection of War Victims, held at Geneva. He was asked about the position of doctors who were prisoners of war, and said that a number of medical prisoners would be exchanged for similar personnel from the enemy country, but some prisoner-of-war doctors would be retained to look after their compatriots in prison camps. He believed the conditions as established by the new conventions were better than those prevailing during the recent war.

The final observer report was from Unesco, on which Dr. Cibrie made a brief statement. He said that collaboration with Unesco was likely to be very useful both for that organization and for their own, and it was important that the contacts should not be reduced.

Mme. I. M. Zhukova, who represented Unesco as an observer at the assembly, brought the greetings of the Director-General, and gave an account of the work of Unesco, particularly in initiating—at a time when there was no other body to undertake the task—the co-ordination of international medical congresses. She said that Unesco had set up an independent non-governmental liaison committee between itself and WHO, with its headquarters in Brussels. There was no intention to interfere with the agenda of international medical meetings, but only as far as possible to arrange time and place in such a way as to afford the maximum convenience to those attending. A calendar of international congresses would be published.

Dr. Sen asked how many members of the medical profession were on Unesco committees. On the national commission in the United States he understood that there was no representative of the American Medical Association. What was the composition of this independent body established by Unesco and WHO?

Mme. Zhukova said that it was for the national medical associations to ask for representation on commissions of Unesco.

Dr. Sondervorst (Belgium) testified that the new committee set up in Brussels was non-governmental. He hoped that the Secretary-General of WMA would be instructed to get in contact with this new organization with a view to participation.

Dr. Routley (Chairman of Council) said that the Council was not fully informed when it passed a resolution on the subject of the permanent committee for the co-ordination of international congresses of medical science. Therefore he suggested that the debate be adjourned, and that the whole matter be referred back to the incoming Council for reconsideration. The WMA were concerned to secure the closest co-operation with all other world bodies which had a place in the field of health.

It was agreed to remit the matter for the consideration of the incoming Council.

Next Meeting of the Assembly

The President said that it had already been agreed that the United States should be selected as the country for the 1950 session of the assembly, but this required confirmation by the present meeting.

Dr. Routley formally moved and Dr. R. L. Sensenich (United States) seconded that the meeting in 1950 be held in the United States, and this was agreed to.

Dr. Taalman Kip (Netherlands) said that he did not oppose the motion, but at the same time he pointed out the time and expense involved for European and other delegates attending a meeting in the United States. The Secretary-General said that the meeting would be held in October, at a period of the year when reduced passenger fares came into operation, and this reduction might compensate for the disadvantage arising out of devaluation. Moreover, in America they were anxious to help delegates from the sterling area, and a certain amount of hospitality would be forthcoming.

The second day of the assembly then concluded. On the following day there were no meetings, and an excursion to Windsor, Eton, and Hampton Court was arranged.

Social Security and the Medical Profession

The last day of the assembly, October 14, was devoted to the discussion of a report on social security, the work of a committee of which Dr. Charles Hill was chairman and Dr. Paul Cibrie, Dr. P. Glorieux, Dr. E. L. Henderson, and Dr. Dag Knutson were the other members. The report was presented by Dr. Hill, Dr. T. C. Routley temporarily presiding.

Dr. Hill said that wherever schemes of social security, embodying medical services, were being evolved, the medical profession was presented with the problem of preserving—in the interests not of the medical profession but of the public—the essential freedoms of the profession in the conduct of its work. Bearing in mind that it was not the role of the World Medical Association to dictate to its member-associations the line they should take in dealing with schemes in their respective countries, his committee had begun the preliminary work of survey, and the report now presented was a factual summary of the conditions in 24 countries. Governments were closely associated together in these matters, each government making a careful study of what was going on elsewhere. Information was passed from government to government, and because of this intergovernmental activity it was only right that the medical profession in each country should be informed of what was going on elsewhere. The function of the World Medical Association was to provide an international forum for the expression of the views of the profession on relations with governments. It was important that the profession should be informed of the trend of governmental activities, should maintain a wise vigilance, and should be prepared to resist tendencies which threatened the freedom of the profession.

National Health Service in Great Britain

Dr. H. Guy Dain made a short statement on the early experience of the new National Health Service. The British Government had been warned beforehand that there was not sufficient provision to establish a free service of all medical requirements for the entire population in one jump, but the Minister believed in "the method of teaching you to swim by throwing you in and seeing what happens." The profession in Great Britain had urged a general medical service for the nation for many years, but it had not expected that a free service for the entire population would be brought in other than gradually. The inevitable had happened, that where a community found itself entitled to a free service it made immediately the maximum demand. The Service had been inaugurated without a sufficient provision of doctors, nurses, hospital beds, and material equipment. The consequence was that doctors had been overworked, there were long waiting-lists at hospitals, and with regard to material provision, such as spectacles, the demand had far outstripped the supply. Some means must be found of bringing the demands within reasonable control. It had been suggested that a small, but not prohibitive, charge should be made for various articles supplied.

The position of the medical profession had been made very difficult. The remuneration of the general practitioner had not been finally settled, and consultants and specialists had only recently been acquainted with their terms and conditions. The profession held that the freedom of the patient to choose his doctor was essential to the progress of medicine and to the proper relationship of doctor and patient. They had opposed from the beginning any idea of a salaried service, because that inevitably limited the right of choice. The doctor should also be free to act within his discretion as to the kind of practice he undertook and the place in which he practised. This had been attained in the British system. The profession also considered it essential that private practice should be continued side by side with any State service. In this respect they had only partially succeeded, and the opportunities for private practice in the field of general practice were limited, partly because the Government would not allow the private patient to obtain his drugs and dressings within the Service. He was convinced that private work outside the State Service should be maintained. A few hospitals privately owned and supported were independent of State control and possibly represented the beginning of a free service outside the State Service.

Great Britain, with a long history of contract practice, had approved a system of capitation payment for general practitioners; he knew that this method was not favoured in some other countries, but it did save the doctor from being dependent on the State or on a superior officer in the State Service. In a Service which embraced 95% of the population, and upon which so large a proportion of the doctor's income depended, it was important that doctors should be free to express themselves in any way they liked, not only about medicine in general but about the Service itself.

What had been the effect of the Service on medicine and on doctors generally? At the moment there was disorganization. The rush of work was such that many doctors complained that they could not give their patients as much time and attention as they desired. That was a temporary phase which would be corrected as doctors became better distributed. On the subject of remuneration, the size of the general practitioners' pool had not yet been agreed; the total amount was still the subject of negotiation. The difficulties of the rural practitioner had been largely overcome by an addition to what was called the mileage fund, but which in fact included the time as well as the mileage factor. The doctors who had suffered most were those in practice in the higher-class residential areas. The private patients from whom they had formerly drawn their income were now National Health Service patients. Until some readjustment had taken place in the number of doctors practising in such areas, and some weighting of the capitation fee was made for the first thousand patients on a doctor's list, so that a doctor who had necessarily a small list owing to the circumstances of his area would not be so gravely disadvantaged, this difficulty would continue.

This was only a brief outline of the "teething troubles" from which they had suffered in Great Britain during the first year; it might have some interest for those in other countries who might have to face similar developments.

Continental Opinion

Dr. Paul Cibrie (France) objected to the capitation fee method of payment, which he thought put the doctor at the mercy of the patient. In France and Belgium payment was made on an item-of-service basis according to a fixed tariff. Dr. P. Glorieux (Belgium) said that in his country a scheme of health insurance was started without any consultation with the medical profession, but the cost was considered to be too high, and now a commission was sitting to consider the question anew. Dr. O. Leuch (Switzerland) considered that social insurance was needed only for people below a certain economic level; other persons should be treated on a voluntary or private basis. In Switzerland social sickness insurance embraced the whole family, and specialist and hospital services were included.

Dr. Dag Knutson (Sweden) described the projected Swedish programme of comprehensive and compulsory social insurance, with the transformation of all doctors into Civil Servants controlled by the State. The Swedish Medical Association had set up a committee of doctors with experts in economic questions to work out the cost of the proposed service. This was difficult because of the vagueness of some parts of the Government's proposal. But it was believed that the inauguration of the

programme would cost £70 million, and the annual cost would be over £50 million. At present taxation in Sweden was at a forbidding level, a number of people paying from 40 to 60% of their total income in taxation. In the view of the Swedish Medical Association, which favoured an extension of the insurance scheme which already covered 60 to 65% of the population, the proposed system was incompatible with free choice of doctor.

Dominion Experience

Dr. W. Magner (Canada) said that in May, 1948, the Prime Minister of Canada announced a national health programme in which some 30 million dollars a year was to be made available to the Provinces for the improvement of health services. The Canadian Medical Association, which had for long been on record as approving the principle of contributory health insurance, met in June of this year and formulated its policy, which he read to the assembly. This favoured a system of health insurance, and declared that the Canadian Medical Association would oppose any Act modelled on the British Act and any conditions of general practice such as were imposed on British general practitioners. Government subsidies for the medical care of the lower income groups were welcomed.

Dr. L. L. Davey (Australia) said that the Pharmaceutical Benefits Act, which provided free pharmaceutical benefits according to a formulary and on the prescription of a doctor, was apparently a dead letter, following a recent decision of the courts. The National Health Services Act had not yet been proclaimed; it was only an enabling measure, and the details of the Service would be determined by regulations, which had not yet been promulgated. The medical profession had laid down certain conditions, which were unacceptable to the Government. In Australia the poorer no less than the middle and upper classes had always been assured of service.

Dr. J. H. Harvey Pirie (South Africa) said that ten years ago the Medical Association of South Africa put forward a scheme for a National Health Service; he doubted whether they would put forward a scheme of the same kind to-day. They were more likely to call for a system of national insurance so far as the white population was concerned. The medical profession in South Africa had won the first round of its fight against an Act whereby all persons would have had a complete free hospital and medical care service, and had now a breathing space in which to organize themselves further.

The Issue in the United States

Dr. W. Cline (United States) said that any scheme on a comprehensive federal basis in the United States would be beset with difficulties on account of the great disparity as regards population density in the different regions. The complications were greater than in a smaller and more homogeneous country. The American Medical Association believed that progress in medicine could be best promoted by preserving the freedom of the profession. It had not accepted any participation with the Federal Government in supplying coverage for groups that could not easily afford medical attendance. Rather it looked upon the indigent as the responsibility of the local community. their medical care to be provided by doctors at no charge or such charge as could reasonably be made, and their care in hospital to be provided by public or charity institutions. With this end in view the profession had endeavoured to develop and enlarge the voluntary insurance system. There were a number of voluntary plans in the States adapted to the economic circumstances of different communities. Various proposals had been laid before them during the last ten years for systems of compulsory health insurance, somewhat similar to the Health Service Act in Great Britain, and likely to confer upon one individual or department powers similar to those of the Minister of Health in this country. It had been stated that large sections of the current proposals before Congress had been taken bodily from the British Act. This was regarded as a purely political move on the part of people concerned to attract votes. Compulsory health insurance was "the foot in the door." The result would be Government dictation in medicine. The profession was determined to fight the domination of medicine by the Government, and already the efforts it had made had brought about a material change in public opinion. Apart from this, the other issues involved in social security were not the direct concern of the medical profession.

Dr. S. C. Sen gave a brief account of the situation in India. There were at present about 50,000 qualified doctors for a population of 350 million, but in addition there were five times that number of practitioners practising the ancient systems of medicine. The Government of India had in preparation a scheme to provide a medical service with cash benefits for sickness, maternity, and occupational injury for about five million industrial workers. It was expected that funds would be derived from compulsory insurance contributions. It was not yet known whether medical treatment would be provided through a panel system or by full-time medical officers.

A Continuing Study

In closing the discussion Dr. Hill said that the discussion had shown that at future assemblies a prominent subject on the agenda on each occasion must be social security. The exchange of information was not only of value in keeping the record straight and in stimulating national medical associations to interest themselves in this problem, but it would have the effect of sparing the necessity for criticisms based on lack of information or on inaccurate information. In this report a beginning had been made in the collection of facts. It would be necessary to compare the facts so collected with those obtained by governmental and intergovernmental organizations. This work was the most important to which the Association had set its hand.

The various factual reports were adopted, and the assembly agreed on the recommendations of Council to invite each national member-association to furnish details of the total annual cost of the social security scheme in operation in its country or of the estimated total cost of any proposed scheme, and of the proportion of the national budget which the cost of any such scheme involved. The national associations are also to be asked to give their considered opinion on the results of social security based on the experience gained in their own countries, and to furnish various other information. The information thus forthcoming is to be circulated in a quarterly bulletin for the information of national member-associations.

The Chairman of Council (Dr. Routley) expressed to Dr. Hill and his committee the thanks of the assembly for their labours.

Closing Proceedings

The assembly, which meets in the United States in 1950 and in Sweden in 1951, had three invitations for 1952—from Canada, Cuba, and Greece. The choice of venue was left to the Council.

Dr. R. L. Sensenich (United States) moved, and Dr. L. G. Tornel (Spain) seconded, that Dr. Elmer Lee Henderson, of Kentucky, U.S.A., Fellow of the American College of Surgeons, and President-elect of the American Medical Association, be President-elect of the World Medical Association, and this was agreed to unanimously.

Dr. Henderson, in accepting the nomination, said that in the United States they had great hope for the future of the WMA, not only from the standpoint of promoting medical care in all countries of the world, but from that of establishing world peace.

The three retiring members of Council—Dr. P. Cibrie, Dr. Dag Knutson, and Dr. J. A. Pridham—were re-elected.

Dr. Henderson then proposed a vote of thanks to the British Medical Association for the arrangements it had made for the assembly, to Dr. Charles Hill for the excellent way in which he had presided over the assembly, to the interpreters for their able assistance, and to the Ladies Committee for providing entertainment for ladies accompanying the delegates.

The vote of thanks was carried with enthusiasm, and Dr. Hill, after acknowledging the compliment on behalf of the British Medical Association, expressed his own thanks to the Secretary-General (Dr. Louis Bauer) and his staff for all that they had done to ensure the outstanding success of the third assembly.

COUNCIL DINNER

At the conclusion of the assembly of the World Medical Association on October 14 the Council of the British Medical Association gave a dinner in the Great Hall in Tavistock Square. It was the first occasion since before the war that a Council dinner has been held in the building, and the presence of so many delegates from foreign countries, with their ladies, gave special significance and colour to the gathering. The guests, to the number of 211, were received by Dr. E. A. Gregg, Chairman of Council, and Miss M. Gregg. In proposing the toast of the World Medical Association Dr. Gregg said what a pleasure it had been to the Association in London to act as hosts and to have an opportunity of returning the welcome which was given to the British guests at the two earlier assemblies in Geneva and in Paris. Another reason why the B.M.A. was glad that the international body had come to London was because it had seen fit to honour Dr. Charles Hill by making him its President. In the British Medical Association they held Dr. Hill in very high affection. He was a wonderful man and he was going far before he had finished his course. They were proud and honoured that it was in the British Medical Association he proved his abilities and found his voice.

Dr. Charles Hill remarked that it would be an under-statement for him to say that he was proud to be in a position to respond for the WMA, particularly when its meeting was held in that building. It was perhaps inevitable that while enjoying the temporary glory of the chair during the past week he should have made comparisons between the assembly of the WMA and the Representative Body. The former, though embracing many nationalities and races, from Iceland to Australia and Cuba to Pakistan, was relatively placid. It lacked the tempestuous tone which had characterized recent Representative Meetings. This was partly due, no doubt, to the fact that it had been necessary to interpret all the speeches in another language, and during the interpretation any feelings which might have been aroused had a chance to simmer down. One thing which his temporary occupancy of the chair had shown him was that the wisdom and efficiency of a Chairman or President were largely due to the promptings of an efficient Secretary. He had noticed a certain succinctness about Dr. Louis Bauer's adjurations to the occupant of the chair which he himself would endeavour to imitate when he resumed his secretarial seat. During the week the assembly had discussed an international code of ethics, postgraduate medical education, and social security, but the one thing that mattered most of all was the contribution which such meetings made to international relations and world fellowship.

Dr. T. C. Routley recalled the inaugural meeting held at B.M.A. House in 1946, when Sir Hugh Lett (whom they were glad to see present that evening), with great patience and tolerance, assisted at the birth of this lusty infant. Dr. Elmer Henderson, President-elect, made a further response, and said with what pleasure they would welcome the next assembly in the United States.

Dr. L. G. Tornel then in a tornado of Spanish eloquence proposed the health of the British Medical Association, speaking of England as a country of noble traditions and love of freedom. Dr. Paul Cibrie added a few words in praise of the generous hospitality and what he called the graciousness of the British hosts. A response was made by the President of the British Medical Association, Dr. C. W. Curtis Bain, who spoke of the broadmindedness of the WMA, as exemplified in the fact that, although the subject of therapeutic abortion had come forward and had elicited sharply contrasting views, it had been quickly settled in what they used to think was a peculiarly British way, but which was evidently a world medical way, of compromise without forfeiture of principle.

To the great pleasure of the company Sir Lionel and Lady Whitby arrived before the proceedings closed, having come direct from the boat which brought them back from their American and Canadian tour. Sir Lionel Whitby in a few graceful words proposed the health of the ladies, remarking on the contribution they could make to international peace and fraternity, and a response was given by Mme. O. Leuch, of Switzerland.

HEALTH CENTRES

PRIVATE PRACTICE AMENDMENT

The Minister of Health tabled an amendment for the Report Stage of the National Health Service (Amendment) Bill the effect of which is to enable a general practitioner practising from a health centre to see and treat private patients there. The amendment reads:

Page 22, line 9 (Schedule), at end, insert—

At the end of paragraph (*a*) of subsection (1) of section twenty-one (which requires facilities at health centres to be available for the provision of general medical services), there shall be inserted the words "and, on such terms and conditions as may be determined by the Minister, for the provision by medical practitioners of such other personal medical services (if any) as may be so determined in the case of a particular health centre."

Opinions differ on whether private practice from a health centre is desirable or not. Advocates of the scheme point out that practice expenses may be reduced, since the doctor would not need to have a surgery and other facilities at his home. On the other hand some fear that if private patients are treated at health centres they may cease to enjoy those few advantages that induce them to remain as private patients, and that therefore private practice would disappear.

HOSPITAL DENTAL STAFF

The Ministry of Health has informed hospital boards that they should now offer permanent contracts to all grades of dental officer on their staffs in accordance with the published Terms and Conditions of Service.

DISCIPLINE AND PUBLICITY

Proceedings before medical service committees are private, and reports of these committees go to executive councils for consideration. A circular from the Ministry of Health states that the Press should not be admitted while an executive council is discussing a medical service committee's report, but they should normally be admitted when a decision has been reached, and told the decision. The Minister suggests that it might be convenient if the council were to publish a summary of the case and of the findings.

Further Publicity

In due course the council is notified of the Minister's decision. The council may then give further publicity, and the Minister considers that that would be desirable in serious cases. A summary of the case could be published, together with a report of the Minister's decision.

No Names

The circular states that at no stage should the names of the parties to the proceedings be mentioned, or particulars which might lead to their identification.

OCCASIONAL ATTENDANCE ON ARMY PERSONNEL

The Association has received several complaints in recent months in cases where doctors have experienced considerable delay in obtaining payment from Army funds of fees due in connexion with the treatment of soldiers "sick on leave" or on the lodging list. The War Office has pointed out that no undue delay should occur if the completed Army Forms O.1667 are sent to the Assistant Director of Medical Services of the local district, or to the Deputy Director of Medical Services of the Command in which the doctor is practising. Members are advised, therefore, to follow the procedure outlined above and not to send accounts to the officer commanding

the unit concerned (which, however, is still the procedure for R.A.F. personnel). •Addresses of D.Ds.M.S. are as follows :

Headquarters, Eastern Command, Hounslow, Middlesex. Headquarters, Northern Command, York. Headquarters, Western Command, Chester. Headquarters, Southern Command, Salisbury, Wilts. Headquarters, Scottish Command, Edinburgh.

Addresses of A.Ds.M.S. of local districts can be obtained from the D.D.M.S. of the Command concerned. Initial requests for copies of A.F.O.1667 should be made to these officers and not to the officer commanding the soldier's unit. The forms are also obtainable from the local executive council.

Questions Answered

Circular to General Practitioners

Q.—*I am in full-time employment as a surgeon, and shortly changing over to part-time hospital work and entering private consultant practice. What form of circular may I send out to the general practitioners of the district acquainting them of this fact?*

A.—There is no ethical objection to a circular letter being addressed to any practitioners in the area who may reasonably be expected to be interested. The circular should be brief and should confine itself to a statement (for example) that "Mr. X is now available to see private surgical patients by appointment at (address). Telephone No.: 1234." The letter should be enclosed in an envelope, which need not be sealed.

The ethical considerations to be borne in mind are such brevity and simplicity of announcement as are consistent with clarity, and a reasonable restriction of the field of circularization.

Examining Hospital Employees

Q.—*I am a whole-time medical registrar at a teaching hospital and examine weekly, prior to their engagement on the hospital staff, domestics, porters, cooks, stenographers, etc. Am I entitled to any fee for performing these examinations, and, if so, what is the fee?*

A.—A whole- or part-time medical officer in contract with a board of governors is not entitled to claim a fee for the examination of employees or prospective employees of the hospital where he is engaged.

No Fee Allowed

Q.—*Is a whole-time officer forbidden from charging a fee for a private consultation carried out in his own home outside the usual hospital working hours or at the week-end?*

A.—A whole-time officer is not entitled to undertake private practice. This is laid down in the Terms and Conditions of Service of Hospital Medical and Dental Staff, paragraph 14.

Practising Elsewhere

Q.—(*a*) *I am in general practice under the National Health Service Act and I wish to change from one area to another. How do I go about it?* (*b*) *Will my compensation be based on my new practice or my old one?*

A.—(*a*) If a general practitioner giving general medical services under the National Health Service wishes to leave his present practice he may do so by giving three months' notice to the clerk of the local executive council or such less period as may be permitted in a particular instance.

The practitioner may either study the advertisements of vacancies and make application for those that interest him, or he may apply through the local executive council to the Medical Practices Committee for permission to practise in the area of his choice. If this is not a closed area, the consent of the Medical Practices Committee is automatic unless the number of applicants exceeds the number required for the area to be adequately doctored. Application may also be made to the Director of the Medical Practices Advisory Bureau at B.M.A. House, who may be able to put him in touch with a practitioner who wishes to obtain a successor.

(*b*) The amount of compensation to which the doctor is entitled (and on which he receives payment of interest) is assessed in regard to the practice in which he was engaged on July 5, 1948, and does not alter. Under the Act it is payable on retirement from practice as a medical practitioner providing general medical services under Part IV of the Act, but payment cannot be made at the present time, as the total amount of all claims for compensation is not yet known. A change from one practice to another does not constitute retirement for this purpose.

Certificates for Corsets

Q.—*In reference to the Questions Answered paragraph "Certificates for Corsets" in the Supplement of August 27 (p. 115), I should be grateful if the position be still further clarified. Does a prescription for a corset for any disability exempt the garment from purchase tax, or has the disability to be one of a number of named disabilities laid down by the Government department concerned?*

A.—Customs and Excise Purchase Tax Exemption Schedule 78 sets out those disabilities which on production of the necessary medical certificate exempt the purchaser from purchase tax on a corset.

Retrospective Pay

Q.—*With reference to retrospective pay, am I entitled to this as regards a post to which I had been appointed before July 5, 1948, but which did not become vacant till a little after this date, and where the salary was raised after the completion of my appointment? If I am entitled to such pay, where and when am I to apply?*

A.—In general the salary of hospital medical staff will be adjusted in accordance with the practitioner's recent grading on the basis of the terms and conditions of service retrospectively to July 5, 1948, or to the date of appointment, whichever is the later. Where different posts have been held, the adjustment will take into account the grading of each appointment. Thus in the case of registrars the posts held from time to time since the appointed day will be reviewed and classified in accordance with the new grading and remuneration then adjusted retrospectively. In the case of house officers, the period since registration will be divided into six-monthly periods, the salary for the first six months being calculated at £350, for the second at £400, and thereafter at £450 per annum.

The practitioner should apply to the employing authority for payment of any sum to which he is entitled in respect of the expired appointment.

National Insurance Contributions

Q.—*At present I am doing a locum for a doctor who had a car accident. Prior to this I had done a hospital job, and between ending it and obtaining the locum I was unemployed for a week. This locum finishes this week, and when it ends I intend to take driving lessons, during which time I do not wish for another position. I intend, therefore, to be unemployed for about a month. I would be much obliged if you would let me know what contributions I have to make under the National Insurance Acts for the period I was unemployed before the locum, and for the period of my locum; and what the position is with regard to the National Insurance Acts for the subsequent period of virtual unemployment. I would also like to know the position with regard to superannuation for the period of my locum. If you could clear up these points I would be most grateful.*

A.—As an employed male person your employee's contribution is 4s. 11d. per week. When unemployed you pay 4s. 8d. as a non-employed person unless a "credit" is obtained by registering as unemployed at an employment exchange. The employment of a short-term locumtenent by a principal does not involve any superannuation scheme. This differs from the case of an assistantship. If you have previously been subject to a superannuation scheme you should ascertain from your previous employer the position regarding past payments.

Retrospective Pay for Housemen

Q.—*Is retrospective pay up to the present scale of remuneration payable from July, 1948, to persons employed as house-physicians at that time (and for the remainder of the year)?*

A.—The Ministry has laid down that, in applying the new rates for house officers retrospectively to the appointed day, the period since registration during which posts in this grade have been held should be divided into six-monthly periods (irrespective of the period of tenure which in practice attached to the posts). The remuneration for the first six months after registration is calculated at the rate of £350 per annum, for the second six months at the rate of £400 per annum, and thereafter at the rate of £450 per annum.

Therefore the questioner would appear to be entitled to retrospective adjustment of salary at the rate of £350 per annum in respect of the period July 5–August 31, 1948 (i.e., that part of his first six-monthly appointment which comes within the National Health Service), and at the rate of £400 in respect of the period September 1–December 31. The principle of retrospective application of the terms has been determined by the Ministry, and the practitioner should press his claim with the hospital.

HEARD AT HEADQUARTERS

A New Word

It came with dreadful suddenness upon our ear recently in listening to a public address by one of the principal medical officers of the Ministry of Health—the word "pathologize." He spoke of a patient being "*x*-rayed and pathologized," meaning, of course, submitted to various pathological examinations. This sort of thing comes trippingly to the tongue. It is not so long ago that the word "hospitalize" was minted. "Anatomized" is, of course, already in the *Oxford*. It will not be long before a patient is "clinicized" or a pregnant woman "obstetricized."

Sweden To-morrow

A few days spent in Stockholm recently were sufficient to reveal to one the outstanding excellence of the Swedish hospital system. In Sweden, we were told, only 3% of hospital beds are in private institutions. Sweden is looking forward next year, or in 1951, to the introduction of a comprehensive and compulsory health scheme. Every Swedish citizen will then be entitled to free treatment at the public hospitals. Certain basic medicines will be dispensed free; others at half price on presentation of a doctor's prescription. Three-fourths of the doctor's fee will be paid for under the scheme, as well as the travelling expenses of the patient, with compensation during the period of his illness, and the patient will be able freely to choose his doctor. Under the present health insurance scheme about 60% of the adult population participate, and the health insurance or sick benefit organizations, which are recognized by the Government, pay two-thirds of the doctor's bill. Sweden's great problem is the shortage of doctors—4,000 to serve a population of 7,000,000, a ratio of 1 to 1,750.

Insomnia

A patient seeking sleep that knits up the ravelled sleave of care hopes to get help from the Health Service in a novel way. A doctor tells us that he has received the following letter from her: "Dear Dr. X, I wonder if you could possibly let me have a certificate to get a small electric massage machine through the National Health Service. I have been suffering from insomnia during the last year or so, and do not want to take any tablets, etc., in order to cure this. I am in fact rather nervous of them. But I do think that about 10–15 minutes' massage every evening before going to bed would have a very soothing effect, and would do the trick. If you could possibly help me in this way I would be very grateful."

The Language Difficulty

The language difficulty was well surmounted at the WMA, although the delegates who came to London spoke, between them, at least sixteen languages in their own homes and practices. Here they spoke remarkably well in French or English, and some of them in both, interpreting their own speeches. Interpretation doubles the length of the proceedings, but, as Dr. Hill suggested, it may do something to becalm them. The WMA interpreter, Dr. Gérin-Lajoie, of Montreal, was a two-way man. Usually in international assemblies two interpreters are employed, one to turn French into English and the other to turn English into French, but Dr. Gérin-Lajoie did it both ways without turning a hair, and was as fresh as paint at the end of the day. Miss Roverano also gallantly assisted on the Spanish side, though her interpretations were mainly *sotto voce* for the benefit of the two or three delegates who needed the Spanish.

GENERAL MEDICAL COUNCIL

ELECTION OF DIRECT REPRESENTATIVE

Practitioners in England and Wales will receive within the next few days voting papers for the purpose of electing a Direct Representative of the profession to the General Medical Council to fill the vacancy occasioned by the death of Dr. J. W. Bone. Dr. O. C. Carter, of Bournemouth, has been chosen as the Association's candidate, and his Election Address is set out below. All members of the Association are asked to cast their votes for Dr. Carter.

Dear Sir or Madam,

I have the honour to offer myself for election as a Direct Representative of the profession on the General Medical Council. I believe the best qualifications a candidate for the office of Direct Representative can have are a long and wide experience in the practice of his profession and a sound knowledge of the many difficult and varied problems that confront the profession. I believe that reforms are needed in the constitution, functions, and procedure of the General Medical Council, and I support strongly the recommendations of the British Medical Association, among which appear the following:

Every complaint made to the Council should be supported by an affidavit.

The Council should be empowered and required to establish two distinct and separate committees to be known as (*a*) the Penal Cases Committee; (*b*) the Disciplinary Committee.

No member of the Penal Cases Committee should be permitted to sit as a member of the Disciplinary Committee hearing any case which has appeared before the Penal Cases Committee at which he was present as a member.

The attendance of witnesses and the production of documents before the Disciplinary Tribunal should be enforceable by subpoena, and evidence should be given on oath.

There should be a right of appeal to the High Court against the removal of a practitioner's name from the *Medical Register*.

If elected to the General Medical Council I shall press for such revision of medical education as will bring it into closer correspondence with the progress of knowledge and the requirements of modern practice.

My candidature has been endorsed by the Divisions of the B.M.A. in England and Wales. I assure you that if I am elected I shall devote to your service whatever time and energy may be necessary to the further fulfilment of my duty as Direct Representative. I ask you to accord me your vote, and I shall be grateful for your active assistance in securing the votes of your colleagues.

I submit my qualifications for the position of Direct Representative: I was Division Secretary for 23 years; I was a member of the Spens General Practitioners Committee; I am a member of Council British Medical Association and of the General Medical Services and Central Consultants and Specialists Committees.

Yours faithfully,

O. C. CARTER.

Hursley, Poole Road, Bournemouth.

SCOTTISH COMMITTEE

The first meeting of the new session of the Scottish Committee was held at B.M.A. Scottish House, Edinburgh, on October 4. Dr. I. D. Grant (Glasgow) was elected chairman in succession to Dr. George MacFeat (Lanarkshire), and Dr. J. G. M. Hamilton (Edinburgh) was elected deputy chairman.

In proposing the appointment of Dr. Grant as his successor, Dr. MacFeat commended the setting up of small study groups throughout the country to work on problems as they occurred locally. The groups, working through the machinery set up by the Association, could help towards practical solutions and influence future developments. In watching the development of the Health Service during the first year he had been deeply disturbed by the signs of deterioration in the position held by the general practitioner.

In accepting office, Dr. Grant paid tribute to the competent and unselfish service of Dr. MacFeat. Many members of the Scottish Committee, he said, had probably felt that much of its importance was removed when certain other committees became autonomous. It remained important, however, to have a widely representative body such as the Scottish Committee to watch the interests of all sections of the medical profession.

Dr. P. Martin Brodie (Edinburgh), Dr. I. Simson Hall (Edinburgh), and Dr. J. B. Miller (Bishopbriggs) were co-opted to the committee.

Alterations to the Scottish House

Dr. E. A. Cormack, chairman of the Building Subcommittee, and Mr. W. H. Kininmonth, architect, outlined the alterations and improvements proposed on the Scottish House property. These provide for more adequate accommodation for the meeting of members in both a business and social capacity. The reconstruction will provide improved accommodation not only for the Association but also for the Medical Insurance Agency. At present there are no catering facilities in the building, and it was proposed therefore to provide a members' dining-room. In the meantime snacks, light lunches, teas, etc., will be served. Mr. Kininmonth had estimated the cost, including equipment, at £15,000, but the final cost would probably be higher. The total cost of the project, including furnishings, would be about £20,000.

The Scottish Committee approved the plans and remitted the matter to the Central Building Committee.

Other Business

On the question of police fees, Dr. Grant said conditions in Scotland differed materially from those obtaining in England. He thought they might have a report on the position. The committee agreed that the Scottish Secretary should take the matter up with the Crown Office and thereafter submit a report to the Chairman's Subcommittee.

Representatives were appointed to meet the National Committee for the Training of Teachers on the question of equal pay for its medical officers.

A communication from the Ministry of Health on the setting up of Whitley Council machinery was remitted to the Whitley Council Subcommittee for consideration.

TRADE UNION MEMBERSHIP

The following is a list of local authorities which are understood to require employees to be members of a trade union or other organization:

Metropolitan Borough Councils.—Fulham, Hackney, Poplar.

Non-County Borough Councils.—Dartford, Wallsend.

Urban District Councils.—Denton, Droylsden, Houghton-le-Spring, Huyton-with-Roby, Redditch (restricted to new appointments), Tyldesley.

Correspondence

Status of General Practice

SIR,—I wish to endorse every word of Dr. Ian D. Grant's letter on the "Status of General Practice" (*Supplement*, October 1, p. 155). The feeling of dissatisfaction which is almost universal among general practitioners under the National Health Service is not entirely, or even mainly, financial in origin, but is due to the futility of a large part of their work, and to the feeling that their status in the Service is becoming lower and lower in the estimation of their specialist and administrative colleagues as well as the general public. Moreover, they themselves feel that their clinical ability is degenerating inasmuch as they are overwhelmed with trivial complaints and have little time and less incentive to improve the quality of their practice of medicine.

Such a state of affairs is inherent in the present set-up of the Service, and can only result in general practice procuring as its recruits the mediocre and the money-grubber; for no amount of financial inducement will attract a good doctor to a job which is a cross between a rubber-stamp and a finger-post.

What, then, can be done about it? Fundamentally there must be an inducement for the general practitioner to improve the quality of his work (and not only the quantity) and an opportunity to raise his professional prestige among his colleagues. A good man must be able to "get on" in the Service, and indeed I know of no other service in which this is not the rule.

I would suggest, therefore, that there be a grading of general practitioners according to their ability, experience, higher qualifications, etc., and that the higher grades would in some measure act in an advisory capacity to their more junior colleagues. Moreover, I would have specialists in most clinical subjects, and especially medicine, recruited from the ranks of general practice, where their vision and wisdom would be enlarged and where their knowledge of human ailments would become more catholic and not directed wholly along the narrow channels of their specialty, as it is now, almost from the date of their graduation. One sees so frequently nowadays the young specialist with great knowledge of disease and little of humanity, great technical skill and little judgment, great learning and little wisdom. I cannot think that this is a state of affairs to be encouraged.

Thus, although the system would not be rigid, the young graduate would normally enter the junior grades of general practice after completing one or two house appointments, and having proved himself in that sphere would have the opportunity of qualifying for the higher grades or branching off into an apprenticeship for his chosen specialty, which he would enter with some practical knowledge of general medicine.

All this would, I think, involve a whole-time salaried service, and although there were very sound arguments against this before July 5, 1948, we have now been jockeyed into a position where we can lose nothing by it, and where many benefits would result to ourselves, the public, and the Treasury. Certainly nothing could be worse than the financial and medical chaos that is going on in general practice at present, and I would prophesy that in the not too distant future the profession itself will beg for a salaried service.

This letter merely contains a number of disjointed and disputable points which require an elaboration beyond the bounds of your correspondence columns, but unless some such revolutionary changes are made the general practitioner will continue to suffer the frustration of a man educated above his job and its prospects, and the National Health Service will suffer the fate of a house built on sand.—I am, etc.,

Selkirk. E. H. DUFF.

Bifocal Glasses

SIR,—I do not understand the reason for the recent Ministry embargo on a patient's having two pairs of glasses at once (*Supplement*, September 3, p. 125), the rule now being that he gets his near-sight glasses in about seven months' time and his

distance ones in about 18 months. There is absolutely no need for anyone to have two pairs of glasses, bifocal ones in the same frame being much better. If the patient goes out with his distance glasses on, in a great many cases when he or she wants to see something—e.g., in a shop—close to, he finds that he has left his near-sight glasses at home on the mantelpiece or has lost them. Without glasses I can see nothing either near or far properly, but some years ago I got fitted with a bifocal pair, and since then have been able to see everything, both near and far, perfectly.

When I write "Bifocal necessary" on the green O.S.C.1 forms I supply to patients I find that in nine cases out of ten the ophthalmic surgeon or optician has turned me down and has told the patient that he needs two pairs of glasses, with the accompanying intolerable delay. As the only G.P. member of our local ophthalmic committee I asked the reason for this, and the answer given by one of the opticians present was, "Pure laziness." Apart from the inexcusable slackness so freely admitted by a member of the ophthalmic fraternity, surely it would be cheaper to have two lenses in one frame than to have two separate pairs of glasses.—I am, etc.,

Stowmarket, Suffolk. H. S. GASKELL.

Pay of Hospital Staff

SIR,—In the issue of September 3 there is an advertisement for an R.M.O. (B1) at the Devon and Exeter Hospital. It states that a senior medical qualification and experience will be required. Does the Devon and Exeter Hospital intend to pay an able man with several years' experience and a higher qualification as a junior registrar? Are all the Spens recommendations now in the wastepaper basket, put there by our own profession? When Mr. Bevan himself has stated that he intended to abide by the spirit of Spens, we find our own profession failing to do so.

No doubt you have good reasons for publishing this advertisement, but it does seem surprising, especially in view of your firm attitude towards cut-price advertisements for assistant M.Os.H. Hospital jobs are difficult enough to get nowadays. Let the successful men be paid a salary in accord with their qualifications and the work they are expected to do.

The fact that the administrative members of the medical profession are grading and paying hospital men far below the scales formerly agreed upon could surely be used as evidence that men in other fields of medicine are being overpaid. Mr. Bevan might justifiably apply the axe all round, merely stating that he was following the example set by our own profession.

While we realize that the assessing committees would not allow this outburst to influence their attitude to our appeals now under consideration, we have accepted the advice of senior colleagues, and sign ourselves

SIX BEWILDERED.

Squatter's Comments

SIR,—The Medical Practices Committee's report (*Supplement*, September 10, p. 128) and the *Practitioner's* review of the Health Service contain material of great interest and importance to general medical practice. But when I correlate my own experiences as a squatter with the truths, half-truths, and discrepancies of these two publications I have a sense of despair and frustration. All we ask is a chance to examine and treat patients and to claim a reasonable living.

It is generally accepted that the best way to enter general practice now is as an assistant. It is the best way because it is the only easy way. But it puts the young and not so young doctor at the mercy of the established practitioner.

The review suggests that the local committees should be given more power to regulate practice in their own areas. The Medical Practices Committee, according to their report, would scarcely agree with that. It is not local knowledge alone that must be considered, but local peculation. If my own local committees had had their way I should not have been able to practise here. As it is I have managed to scrape up a panel of about 1,500 in less than 12 months. That is not much on which to rear five children, but it is a beginning, considering the delay and opposition which I experienced.

The fact seems to be that we cannot expect members of our own profession in positions of authority to behave without prejudice when their own decisions may affect their own incomes, as must be the case with the present system of remuneration. The present attempt at regulated commercialism is not a safe resting-place between complete freedom on the one hand and a full-time salaried service on the other. If the influential members of our own profession continue to act in this way we shall soon be "ripe for the plucking." There will arise sufficient hardship and sufficient unemployment within the profession to enable a Government to bring in a full-time salaried service.—I am, etc.,

L.

Higher Pay without Parades

SIR,—In your issue of September 3 appears an advertisement requesting applications from surgeons, gynaecologists, and E.N.T. specialists to serve with the R.A.M.C. overseas in a civilian capacity. An F.R.C.S. is offered a salary of £1,700 per annum, plus accommodation and other allowances, for a period of up to two years.

Had the same man, in a more patriotic mood, accepted a commission in the R.A.M.C. eight years ago and attained the rank of major and the same qualification he would now be earning a salary (as a bachelor) of £784 15s. plus £73 qualification pay, together with similar allowances and a right to a pension after a further 12 years' service.

It is therefore theoretically possible, in fact probable, that a civilian surgeon could be working side by side with an R.A.M.C. specialist and be drawing twice the pay of the latter without having to attend parades, etc. Such an offer, seen from within the Service, can only increase one's resentment at the delay in bringing specialists' pay into line with that in the National Health Service. Until this is done I consider that such advertisements should not be accepted for publication in the *B.M.J.*—I am, etc.,

MAJOR, R.A.M.C.

Representation of Hospital Medical Staffs

SIR,—In your report (*Supplement*, October 1, p. 151) of the last meeting of the Central Consultants and Specialists Committee you omitted to mention the most important of its decisions.

It was decided, without reference to the regional committees, to agree to the proposal of the Joint Committee that the Joint Committee would appoint and instruct the members of the staff side of the Whitley Council which the Government had announced its intention of setting up shortly. In effect, this decision means that the Central Consultants and Specialists Committee has finally subordinated itself and surrendered the power it was given, when it was constituted by the A.R.M. of 1947, to the Joint Committee, a body which for the most part is not elected even indirectly by or can be fully in touch with the working hospital medical staffs of the country. This in itself is contrary to the meaning of a Whitley Council, which is a committee composed of representatives of the employed staff on the one side and of the employers on the other. As once the medical Whitley Council is set up it will be the Standing Committee for the settlement of disputes or alterations of the terms of service, it will be essential to hospital medical staffs to be able to appoint and instruct directly the members of the staff side of the council. They will not be able to do so through the Joint Committee, over which they will have no control except through the minority of its members derived from the Central Consultants and Specialists Committee.

It was understood when the Consultants and Specialists Committee of the B.M.A. was reconstituted that the object was to provide democratic representation of consultant opinion from the whole country. This appears to have been negatived by the latest action of the Central Consultants and Specialists Committee on a question of major policy, as indeed it was last year, by the setting up of the Joint Committee.

The South-West Metropolitan (Western Area) Regional Committee has, from the first, disagreed on this ground with the formation of the Joint Committee. However, it considers that there may have been some justification for the existence of the Joint Committee during the past year to act as a Liaison Committee between the Colleges and the B.M.A. while the general terms and conditions of service for hospital staffs have been under discussion. But in its view there is now no need or justification for this undemocratic condition to continue. It has noted that the move to form the Joint Committee was made even before the Central Committee had first met, and that the representation of the Central on the Joint Committee was fixed at a small minority.

It has been noted also that the Joint Committee has omitted to report regularly its proceedings to the Central Committee and finally acted without authority in agreeing with the Ministry to recommend the terms for the permanent contracts for hospital staffs, while discarding almost all the points of objection or modification which had been previously put forward by the Regional and Central Committees. Such behaviour does not inspire confidence in the Joint Committee for the future conduct by it of the affairs of hospital staffs, even if the staffs were prepared to waive their right to democratic representation.

The South-West Metropolitan (Western Area) Committee considers that interest in the B.M.A. organization for hospital medical staffs is not likely to be maintained if the Central Committee continues to surrender its power. The lessening attendance at central and local meetings is already an indication of this.

Our committee has decided unanimously that if the Central Consultants and Specialists Committee continues to be subordinated to a Joint Committee it will consider withdrawing its representatives from the Central Committee and relying on representation of its members by other means. The other regional committees of the B.M.A. organization have been informed of this decision.—We are, etc.,

C. B. S. FULLER (Chairman). D. ROSS STEEN.
T. COLLEY. R. F. SWINDELL.
J. D. MARTIN JONES. E. COWPER TAMPLIN.
H. H. LANGSTON. P. G. TODD.
R. G. M. LONGRIDGE. C. HEYGATE VERNON.
R. F. MACHARDY. F. WILSON HARLOW.
M. P. MITCHELL. H. TAYLOR YOUNG.
N. ROSS SMITH. H. C. ZORAB.

Bournemouth. Members of S.W. Metropolitan (Western) Regional Committee.

Freedom Preferred

SIR,—I have read with dismay—indeed with some disgust—Dr. Conn McCluskey's letter (*Supplement*, October 1, p. 157). Surely he is one of an extremely small minority in desiring to be "directed . . . what to do and when to do it," or possibly he has cast himself in the role of a director and not one to be directed.

His statement that "there seems to be little tyranny in the artisans' trade unions" is very far from the truth. Has he not heard of men being debarred from a particular employment because they did not belong to a particular trade union? Has he not heard of restrictions of effort and output being imposed by trade unions upon their members?

He thinks that a "democratically elected body" cannot implement a tyranny. History is full of evidence to the contrary; or, if historical evidence does not seem relevant to him, then all contemporary politics will furnish him with abundant examples to confute his statement.

A state of tyranny must inevitably arise when a tyrannically disposed individual or group of individuals acquires power over a community whose members prefer the security of serfdom to the perils of freedom. In that unenviable predicament I believe the medical profession now to be. I trust we shall not reverse Aesop's fable and add King Log to King Stork by forming a trade union which would be—I hope—as impotent as it would be degrading. The only foreseeable advantage in such an action would be to have attained a point in the spiritual evolution of our profession where we could truly say, "He that is low need fear no fall."—I am, etc.,

Stafford. JOHN FREW.

BRITISH MEDICAL STUDENTS ASSOCIATION

The seventh Annual General Meeting of the British Medical Students Association will be held at B.M.A. House, Edinburgh, on November 11–13. The guest lecture will be given by Mr. P. Eggleton, D.Sc., reader in biochemistry at the University of Edinburgh, on November 11, at 2.30 p.m. Anyone interested is invited to attend this lecture.

Representatives from most medical schools in the country will be attending to discuss such matters as student health services, clinical conferences, staff–student discussions, further-education and training grants, and medical films, as well as routine domestic matters.

B.M.A. LIBRARY

The following books have been added to the Library:

Advances in Surgery. Volume 1. 1949.
American Association of Physical Anthropologists: Studies in Physical Anthropology. No. 1, Early Man in the Far East. 1949.
Atomic Energy Year Book: Edited by John Tutin. 1949.
Banzer, G.: Arzneitherapie des praktischen Arztes. Dritte Auflage. 1949.
Banzer, G.: Medikamentenlehre für Schwestern. 1949.
Bargmann, W.: Histologie und mikroskopische Anatomie des Menschen. Band I, Zellen- und Gewebelehre. 1948.
Berghoff, E.: Max Neuburger, Werden und Wirken: eines österreichischen Gelehrten. 1948.
Berndorfer, A.: Die Asthetik der Nase vom plastisch-chirurgischen Standpunkt aus Betrachtet. 1949.
Bilikiewicz, T.: Psychologia marzenia sennego (The psychology of dreams: Polish text with English summary). 1948.
Böhler, L.: Medullary Nailing of Küntscher. Translated from the 11th German edition by Hans Tretter. 1948.
Breckenridge, M. E., and Vincent, E. L.: Child Development. Second edition. 1949.
Brownell, K. O.: A Textbook of Practical Nursing. Third edition. 1949.
Campbell, J. D.: Everyday Psychiatry: concise, clinical, practical. Second edition. 1949.
Conference, First International Poliomyelitis: Papers and Discussions. 1949.
Conference on National Social Work, Atlantic City, N.J., April 17–23, 1948: Proceedings. 1949.
Congress, International, on Population and World Resources in Relation to the Family. Cheltenham, August, 1948. 1949.
Das, K.: Clinical Methods in Surgery. Second edition. 1948.
Depisch, F.: Die Diät- und Insulinbehandlung der Zuckerkrankheit: für Studierende und Arzte. Vierte Auflage 1949.
Fleming, C. M.: Adolescence. 1948.
Fowler, W. M.: Hematology: for students and practitioners. Second edition. 1949.
Geckeler, E. O.: Plaster-of-Paris Technic. Second edition. 1948.
Goodall-Copestake, B. M.: Theory and Practice of Massage and Medical Gymnastics. Seventh edition. 1949.
Graber, G. H.: Mental Life of the Child. 1949.
Gregory, Sir R.: Gods and Men: a testimony of science and religion. 1949.
Groves and Brickdale's Textbook for Nurses. Seventh edition, revised by J. A. Nixon and Sir Cecil Wakeley. 1948.
Gunther, J.: Death Be Not Proud: a memoir. 1949.
Haire, N.: Everyday Sex Problems. 1948.
Hanby, J. H., and Walker, H. E.: Principles of Chiropody. 1949.
Hansen, H. F.: Review of Nursing: with outlines of subjects, questions and answers. Sixth edition. 1949.
Hansen, I. F.: Investigations on Agonal Acidosis. 1948.
Hay-Shaw, G.: Your Child and You. 1949.
Hinsie, L. E.: Understandable Psychiatry. 1948.
Hoch, P. H. (Editor): Failure in Psychiatric Treatment. 1948.
Horsfall, F. L., jun.: Diagnosis of Viral and Rickettsial Infections. 1949.
Ikin, A. G.: Religion and Psychotherapy: a plea for co-operation. Thesis edition. 1948.
Ingram, M. E.: Principles of Psychiatric Nursing. Third edition. 1949.
Jamieson, E. M., and Sewall, M. F.: Trends in Nursing History. Third edition. 1949.
Jones, E.: Hamlet and Oedipus. 1949.
Jones, E.: What is Psychoanalysis? 1949.
Lee, M., and Wagner, M. M.: Fundamentals of Body Mechanics and Conditioning. 1949.
Mace, D. R.: Marriage Crisis. 1948.
McMurray, T. P.: Practice of Orthopaedic Surgery. Third edition. 1949.
Mayo Clinic Diet Manual. 1949.
Mayo, E.: Social Problems of an Industrial Civilization. 1949.
Meleney, F. L.: Clinical Aspects and Treatment of Surgical Infections. 1949.
Minnitt, R. J.: Gas and Air Analgesia. Fourth edition. 1949.
Neil, J. H., and Neil, T. H.: Ear, Nose, and Throat Nursing. Fourth edition. 1948.

Northern Surgical Association, 23rd Meeting, Stockholm, June 26–28, 1947: Transactions. 1948.
Oakes, L., and Bennett, A.: Materia Medica for Nurses. Third edition. 1949.
Osborn, F.: Our Plundered Planet. 1948.
Piney, A., and Hamilton-Paterson, J. L.: Sternal Puncture. Fourth edition. 1949.
Randell, M.: Training for Childbirth: from the mother's point of view. Fourth edition. 1949.
Saunders, H. St. G.: Red Cross and the White: a short history of the Joint War Organization of the British Red Cross Society and the Order of St. John of Jerusalem during the War 1939–45. 1949.
Schafer, R.: Clinical Application of Psychological Tests. 1948.
Scott, G. E. M.: Juvenile Rheumatism: a clinical survey. 1948.
Smith, A.: Technic of Medication. 1948.
Stopes, M. C.: Birth Control To-day. Ninth edition. 1948.
Taylor, H. P.: A Shetland Parish Doctor: some recollections during the past half-century. 1948.
Taylor, S., and Gadsden, P.: Shadows in the Sun. 1949.
Tidy, Sir H. L.: Synopsis of Medicine. Ninth edition. 1949.
Tidy, N. M.: Massage and Remedial Exercises in Medical and Surgical Conditions. Eighth edition. 1949.
Tobias, N.: Essentials of Dermatology. Third edition. 1948.
Walshe, F. M. R.: Diseases of the Nervous System: described for practitioners and students. Sixth edition. 1949.
Worrall, R. L.: Energy and Matter. 1948.
Yater, W. M.: Fundamentals of Internal Medicine. Third edition. 1949.

H.M. Forces Appointments

ROYAL NAVY

Surgeon Commander S. J. Savage has been placed on the Retired List.

Surgeon Lieutenant R. R. B. Baxendine to be Surgeon Lieutenant-Commander.

ROYAL NAVAL VOLUNTEER RESERVE

Surgeon Lieutenant-Commander E. J. S. Woolley, O.B.E., has been placed on the Retired List.

Surgeon Lieutenants W. E. A. Buchanan, A. C. MacDonald, J. F. McHarg, and R. A. McKeown to be Surgeon Lieutenant-Commanders.

ARMY

Colonel R. S. Dickie, late R.A.M.C., having attained the age for retirement, is retained on the Active List supernumerary to Establishment.

Lieutenant-Colonel J. N. Atkinson, late R.A.M.C., to be Colonel.

ROYAL ARMY MEDICAL CORPS

Lieutenant-Colonel P. E. D. Pank has retired on retired pay, and has been granted the honorary rank of Colonel.

Major D. S. Cochran to be Lieutenant-Colonel.

Major W. N. S. Donaldson, T.D., from Short Service Commission, to be Major.

Captains T. B. Harrison, O. S. Williams, and J. F. Webb, M.C., to be Majors.

Captain C. C. Petrovsky has retired, receiving a gratuity, and has been granted the honorary rank of Major.

Short Service Commission (Specialist).—Captain (War Substantive Major) I. F. Fraser has retired, receiving a gratuity, and has been granted the honorary rank of Major.

Short Service Commission.—Captains J. E. G. Earle and J. M. Corall have retired, receiving a gratuity, and have been granted the honorary rank of Lieutenant-Colonel. Captains I. A. Jackson, M.B.E., and A. J. Leslie-Spinks to be Majors. Captains W. G. Canning and J. P. X. Fox have retired, receiving a gratuity, and have been granted the honorary rank of Major.

REGULAR ARMY RESERVE OF OFFICERS

ROYAL ARMY MEDICAL CORPS

Lieutenant-Colonel (Honorary Colonel) C. B. C. Anderson, O.B.E., having attained the age limit of liability to recall, has ceased to belong to the Reserve of Officers.

Captain B. E. Schlesinger, O.B.E., from Supplementary Reserve of Officers, to be Major, and has been granted the honorary rank of Colonel.

Captains J. P. Stewart, F. A. D'Abreu, R. G. M. Longridge, N. M. L. Lund, J. C. Harland, and G. Macpherson, from Supplementary Reserve of Officers, to be Majors, and have been granted the honorary rank of Lieutenant-Colonel.

Captains D. C. Muir, A. C. F. Green, H. J. Browne, J. H. Chambers, F. G. Wood-Smith, D. P. Kearns, R. Cox, M.B.E., T. J. Fairbank, W. M. Macleod, P. H. Newman, D.S.O., I. N. Samuel, G. C. Steel, F. R. Store, I. H. Griffiths, E. H. C. Harper, G. Lorriman, M.B.E., R. R. Simpson, and A. W. F. Catto, from Supplementary Reserve of Officers, to be Majors.

Captain R. A. Strang, from Emergency Commission, to be Captain, and has been granted the honorary rank of Major.

TERRITORIAL ARMY

ROYAL ARMY MEDICAL CORPS

Lieutenant-Colonel (Honorary Colonel) Sir Hugh W. B. Cairns, K.B.E., has been appointed Honorary Colonel.

Colonels C. P. Oliver, C.B., C.M.G., T.D., and W. D. Watson, T.D., have relinquished their appointments as Honorary Colonels, their tenure of appointment having expired.

Captain (acting Lieutenant-Colonel) G. E. Parker, D.S.O., has been granted the acting rank of Colonel.

Major G. K. D. Edwards has been granted the acting rank of Colonel.

Captains (Acting Majors) M. F. Ronayne, M.B.E., J. G. Waugh, T. P. Sewell, and J. Bleakley to be Majors.

Captains J. Davidson, T. M. Lennox, M. A. Watson, I. R. McNeish, and C. J. Cobbe, M.B.E., to be Majors.

Association Notices

GROUP COMMITTEE ELECTIONS

As a result of elections held recently among the Special Groups, the following have been elected to the various Group Committees. Re-elected members are indicated by an asterisk, and, subject to the amendments shown below, the full list of members of the Committee is as set out in the *Supplement* of August 20 (p. 90).

Anaesthetists Group

Provinces: *Z. Mennell.
*W. W. Mushin.
Scotland: A. C. Forrester (*vice* H. H. Pinkerton).

Consulting Pathologists Group

R. Cruickshank (*vice* A. F. S. Sladden and F. B. Smith).
*J. G. Greenfield.
W. H. McMenemey.

Dermatologists Group

London: D. I. Williams (*vice* L. Forman).
Provinces: *F. F. Hellier.
Scotland: *J. Ferguson Smith.

Orthopaedic Group

London: *P. Wiles.
Provinces: *S. A. S. Malkin.
Scotland: R. Barnes (*vice* A. Miller).

Physical Medicine Group

*F. S. C. Cooksey.
*J. W. T. Patterson.
One vacancy (*vice* J. B. Burt).

Psychological Medicine Group

*P. K. McCowan.
*J. R. Rees.
T. Ferguson Rodger (*vice* A. A. W. Petrie).

Radiologists Group

*J. F. Brailsford.
*S. Whately Davidson.
*J. L. A. Grout.

Spa Practitioners Group

North: T. G. Reah (*vice* L. J. Prosser).
South: J. E. Dawson.

Venereologists Group

R. C. L. Batchelor.
R. Lees.
A. E. W. McLachlan.
C. Hamilton Wilkie.

PRIZES FOR MEDICAL STUDENTS, 1950

The Council of the British Medical Association is prepared to consider the award in 1950 of prizes to medical students for essays submitted in open competition.

The subject of the essays shall be "Clinical Teaching in Relation to the Practice of Medicine."

The purpose of these prizes is the promotion of systematic observation among medical students. In awarding the prizes due regard will be given to evidence of personal observation. No study or essay that has previously appeared in the medical

press or elsewhere will be considered eligible for a prize. Any medical student who is a registered member of a medical school in Great Britain or Northern Ireland at the time of submission of the essay is eligible to compete for a prize.

If any question arises in reference as to the eligibility of a candidate or the admissibility of his or her essay, the decision of the Council of the British Medical Association shall be final. In determining the number and the value of the prizes to be awarded the Council will take into consideration the number of essays received. Should the Council decide that no essay entered is of sufficient merit, no awards will be made.

Each essay must be typewritten or legibly written in the English language, on one side of the paper only, must be unsigned, and must be accompanied by a form of application which can be obtained from the undersigned. Essays must be forwarded so as to reach the Secretary of the British Medical Association not later than December 31, 1949. Inquiries relative to the prizes should be addressed to the Secretary, British Medical Association, B.M.A. House, Tavistock Square, London, W.C.1.

SCHOLARSHIPS IN AID OF SCIENTIFIC RESEARCH

The Council of the British Medical Association is prepared to receive applications for Research Scholarships as follows: An Ernest Hart Memorial Scholarship of the value of £200 per annum, a Walter Dixon Scholarship of the value of £200 per annum, and four Research Scholarships each of the value of £150 per annum. These scholarships are given to candidates whom the Science Committee of the Association recommends as qualified to undertake research in any subject (including State medicine) relating to the causation, prevention, or treatment of disease. Preference will be given, other things being equal, to members of the medical profession.

Each scholarship is tenable for one year starting on October 1, 1950. The scholar may be reappointed for not more than two additional terms. A scholar is not necessarily required to devote the whole of his or her time to the work of research but may hold an appointment at a university, medical school, or hospital, provided the duties of such an appointment do not interfere with his or her work as a scholar.

Conditions of Award: Applications

Applications for scholarships must be made not later than Friday, April 28, 1950, on the prescribed form to be obtained from the Secretary of the Association, B.M.A. House, Tavistock Square, London, W.C.1. Applicants will be required to furnish the names of three referees who are competent to speak of their capacity for the research contemplated.

CHARLES HILL,
Secretary.

Diary of Central Meetings

OCTOBER

21	Fri.	Committee *re* Capital Punishment, 2 p.m.
25	Tues.	Anaesthetists Group Committee, 2 p.m.
25	Tues.	Central Ethical Committee, 2 p.m.
26	Wed.	Joint Subcommittee *re* Remuneration of National Coal Board M.O.s (Conference of Colliery Medical Officers), 2 p.m.
26	Wed.	Spa Practitioners Group Committee, 2 p.m.
27	Thurs.	Annual Conference of Representatives of Local Medical Committees, 10 a.m.
28	Fri.	Library Subcommittee, 11.30 a.m.
28	Fri.	Consulting Pathologists Group Committee, 2 p.m.
28	Fri.	Science Committee, 2 p.m.
31	Mon.	Armed Forces Committee, 2 p.m.

NOVEMBER

2	Wed.	(At Lion Hotel, Shrewsbury) Welsh Committee, 2.15 p.m.
3	Thurs.	Committee on Industrial Health Services in relation to the National Health Service, 2 p.m.
9	Wed.	Committee on the Postgraduate Education of General Practitioners, 11 a.m.
10	Thurs.	General Medical Services Committee, 11 a.m.

Branch and Division Meetings to be Held

BOURNEMOUTH DIVISION.—At Grand Hotel, Fir Vale Road, Bournemouth, Friday, October 28, 7.30 p.m., annual dinner.

CAMBRIDGE AND HUNTINGDON BRANCH.—At Lecture Theatre, Addenbrooke's Hospital, Cambridge, Sunday, October 30, 3.15 p.m. Address by Dr. Robert Forbes: "Legal Hazards in Medical Practice." A discussion will follow.

KENSINGTON AND HAMMERSMITH DIVISION.—At St. Mary Abbots Hospital, Marloes Road, London, W., Tuesday, October 25, 8.30 p.m., clinical lecture. Mr. J. H. Carver: "Male Sterility"; Mr. V. B. Green-Armytage: "Female Sterility." A general discussion will follow.

OXFORD DIVISION.—At Horton General Hospital, Banbury, Wednesday, October 26, 5 p.m., clinical meeting. 7.15 p.m., dinner at Whateley Hall Hotel, Banbury (price 6s. 6d.).

WEST MIDDLESEX DIVISION.—At Nelson Room, Town Hall, Ealing, Friday, October 28, 8.30 p.m., Mr. Angus Maude: "The Conservative Attitude Towards the Health Scheme." Wives are invited.

WEST SUSSEX DIVISION.—At Warne's Hotel, Worthing, Tuesday, October 25, 6 p.m. Business meeting, followed by an address by Dr. Charles Hill on "Problems of the Moment"; 7.15 p.m., dinner (10s., including tip), followed by a discussion. All medical practitioners in West Sussex are invited to attend.

Meetings of Branches and Divisions

LEEDS DIVISION

The newly qualified medical graduates of Leeds University were invited to lunch by the Executive Committee of the Leeds Division on Thursday, September 29.

MASHONALAND BRANCH

The annual report of the Mashonaland Branch Council includes the following statement on State medicine: At the beginning of 1948 the Minister of Internal Affairs met separately both Branches of the British Medical Association in Southern Rhodesia. The verbatim report of the meeting in Salisbury was circulated to all members of the Branch and was discussed at a subsequent meeting. It has been only too obvious to all concerned that the Minister's proposals have not been acceptable to either Branch for the reason that the medical profession does not agree that such proposals will result in any improvement in the health services rendered to the population of Southern Rhodesia, European and African.

In the past there was not only a shortage of hospital beds, nursing staff, and medical equipment, but of medical practitioners as well. This last shortage has been remedied by private enterprise. The Government has failed to remedy the remaining lack, and, because of the Government's policy of providing hospital accommodation at an uneconomic rate to all, no private nursing-homes have been erected, and there is also no adequate private general or midwifery nursing service. The latter might have been remedied if a hostel had been built in which private nurses could live. However, in spite of this lack of private midwives, the Minister proposed to embark on a maternity service designed to encourage women to be delivered in their own homes. It is a matter of opinion whether it is better for a confinement to take place in a hospital or in the home, but without sufficient midwives the answer is obvious.

The Mashonaland Branch has felt in the past that, if the Government is determined to introduce a State medical scheme, the only efficient service would be one controlled by a Commission on which the medical profession is adequately represented. If the medical profession should form part of a Civil Service the Treasury would have the final say, and necessary schemes would not be carried out for lack of funds. The system whereby sums voted this year if not spent cannot be carried forward is iniquitous and leads to money being spent unnecessarily in times of plenty and for essential services to be curtailed in times of poverty. A sinking fund controlled by the Commission would remedy this. The Government's concern should in the first place be with the poorest, and it is feared that any so-called free national health service may result in less money being spent on the poorest and most numerous section of the community—the Africans. At present the medical vote for European and African health services is not divided.

To-day Southern Rhodesia is materially ill-equipped to supply a health service for the community. Given the tools, the private practitioners will render a service to the public more efficiently and at less cost than any other scheme, and if it should be said that the financial burden of ill-health cannot be borne by the individual we can rightly point out that a considerable proportion of the population can be members of medical aid societies, and that it should not be a difficult matter for the Government to provide medical aid in the form of a subsidized medical aid society for those of limited means who could not be members of one of the present societies.

METROPOLITAN COUNTIES BRANCH

Members of the Metropolitan Counties Branch, accompanied by their president, Dr. C. G. Martin, visited the Port of London on September 21 as guests of the Port of London Authority. The party was received by Admiral Sir Allan Hotham, member of the authority, and embarked in the P.L.A. s.y. *St. Katharine* at Tower Pier for a cruise down the River Thames and through the Royal Victoria and Albert and King George V Docks.